DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	DE00187	A. BUILDING _____ B. WING _____	07/14/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWARK MANOR NURSING HOME	154 WEST MAIN STREET NEWARK, DE 19711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced initial certification survey was conducted at this facility from July 7, 2009 through July 14, 2009. The facility census on the entrance day of the survey was 37 residents. The survey sample was composed of 10 residents. The survey process included observations and resident, family and staff interviews. Also included in the survey process was the review of clinical records and facility policies and procedures.	F 000	LTC Residents Protection AUG 04 2009 Director's Office	
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	Resident #2 was affected by not notifying the physician in a timely manner. The resident fell at 7:35am and the physician was not notified until 1:00pm. The resident fell in the third floor hallway. The nurse was notified and assessed the resident. The resident sustained an abrasion under her left eye and a raised area on her left brow which then became bruised. The nurse used our standing orders for treatment. Clean the area with normal saline and betadine and apply a dry sterile dressing as needed. The nurse also placed ice on the area for 20 minutes. Also monitoring of neuro checks. Upon notification of the physician there were no new orders for this resident. The incident was reported to DLTCRP on 1/1/09 at 7:30pm.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lou E. Clemmons RN/DON	DON	8/4/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on clinical record review and review of a facility incident report it was determined that the facility failed to ensure that the physician was immediately notified of an incident with injury sustained by one resident (#2). Findings include: Review of the nurse's note dated 1/1/09 and timed 7:30 AM revealed that Resident #2 was found laying face down in the third floor hallway. Once assisted onto her back Resident #2 was observed with "raised area to (left) eye brow (and) abrasion below (left) eye...". Further record review also revealed that the physician's "office was notified (by) telephone...". According to the facility incident report dated 1/1/09 and timed 7:35 AM the physician's office was notified of the above incident at 1:00 PM. These findings were reviewed with E1 (Executive Director) and RN1 (DON) on 7/14/09.	F 157	All residents that have had an incident were at risk. All incident reports in the past year will be reviewed. We will in-service all professional nursing staff by 8/1/09 in incident reporting and notification on a quarterly basis. As well as any new hires. All incident reports will be reviewed within 24 hours except, incidents that occur over the weekend. Those incident reports will be reviewed by the DON and/or designee on the following Monday. Any incidents that were not faxed to DLTCRP and meet the criteria of reporting will be done immediately by the DON and/or designee. Any staff not complying with the protocol will be subject to disciplinary action. The DON will make up a spread sheet of all incident reports and submit to the administrator on a weekly basis. Tracking of this will be discussed at the quarterly QA meeting.	8/1/09
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a	F 225		

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F 225	Continued From page 2 court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, review of a facility incident report and staff interview it was determined that the facility failed to immediately report and to submit the results of a thorough investigation of an incident of alleged physical abuse exhibited by one resident (#2) to the state agency. Findings include:	F 225	Both residents were without injury. We failed to report this incident to the DLTCRP. Both residents are diagnosed with alzheimers dementia. The one resident stated I was slapped. Upon interviewing staff, residents, and family members it was found that the one resident who was walking around had slapped this resident who was sitting at the dining room table. It remains unclear as to why this occurred it appears to be an isolated incident. The residents were immediately separated and monitored for any further episodes of aggressive behavior. The occurrence of the aggressive behavior was care planned in the residents chart. Also emotional support was given to the resident who was slapped. All residents that have had an incident were at risk. All incident reports in the past year will be reviewed. We will in-service all professional nursing staff by 8/1/09 in incident reporting and notification on a quarterly basis. As well as any new hires.	

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F 225	Continued From page 3 Review of a facility incident report dated 2/13/2009 and tined 12:15 PM revealed that Resident #2 was observed slapping the arm of another resident. In an interview with E1 and RN1 conducted on 7/14/2009 it was confirmed that this incident of alleged physical abuse had not been reported to the state agency. Further review of the facility incident report also revealed the absence of a thorough investigation of the alleged abuse exhibited by Resident #2. The faciity policy, "Reporting of Resident Abuse, Neglect, Mistreatmnet, Serious Injury, Misappropriation of Property and Injury of Unknown Origin" states ""Purpose...A. The proper authorities are notified. B. The appropriate reporting and investigation steps and remedial actions as necessary are taken...".	F 225	All incident reports will be reviewed within 24 hours except, incidents that occur over the weekend. Those incident reports will be reviewed by the DON and/or designee on the following Monday. Any incidents that were not faxed to DLTCRP and meet the criteria of reporting will be done immediately by the DON and/or designee. Any staff not complying with the protocol will be subject to disciplinary action. The DON will make up a spread sheet of all incident reports and submit to the administrator on a weekly basis. Tracking of this will be discussed at the quarterly QA meeting.	8/1/09
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations on 7/9/09 and staff interviews, it was determined that the facility failed to provide maintenance services necessary to maintain an orderly interior. Findings include: 1. Observations at 10:30 AM of resident room 203A revealed that the fall mat cushions were worn. Damaged cushions are difficult to sanitize. An interview with the maintenance director confirmed the cushions would be replaced. 2. Observations at 10:45 AM of resident room	F 253	**No residents were affected by this deficient practice.** **All residents have the potential to be affected by the deficient practice, all issues have been corrected.**	

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F 253	Continued From page 4 207B revealed that the over bed lighting was not functioning. An interview with the maintenance director confirmed that a fluorescent tube was missing. 3. Observations at 11:00 AM of the restroom serving resident rooms 212 and 214 revealed that the ceiling lighting dome was missing. The unshielded bulb was exposed to breakage. An interview with the maintenance director confirmed that the missing dome would be replaced. 4. Observations at 11:15 AM of resident room 219 revealed that the front and bathroom doors were warped. These observations were confirmed by the maintenance director.	F 253	The maintenance department will be starting with a weekly checklist beginning on 8/6/09, these will be reviewed by the administrator or designee on a weekly basis. This will be an ongoing procedure. The weekly checklist will be monitored and reviewed in the quarterly QA meetings, to ensure that all issues are addressed in a timely manner.	8/6/09
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	The resident had a care plan in place his last admission, we failed to update the care plan when the resident arrived for this previous respite stay. All residents that are on a respite stay have the potential to be affected. All respite charts will be reviewed within 72 hours by the DON.	

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F 280	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview it was determined that the facility failed to develop a care plan for one resident (#10). Findings include: Review of the clinical record revealed that Resident #10 was admitted to the facility as a respite on 6/3/2009 with diagnoses that included Alzheimer's disease and hypertension. Review of the clinical record also revealed the absence of a care plan and failure of the facility to implement a care plan during the respite stay of Resident #10 beginning 6/3/2009 and ending 6/16/2009. This finding was confirmed by RN1 on 7/14/2009.	F 280	We have in serviced all professional nursing staff as our policy states. The DON will audit all respite Charts within 72 hours of the admission. The DON/designee will follow up with the administrator on a monthly basis. Any professional nurse found not in compliance will be disciplined. This will be reviewed in quarterly QA meetings.	8/1/09